DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/07/13

PRIN: 11/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445369	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CARE & REHABILITATION CENTER	2750 EXECUTIVE PARK PLACE CLEVELAND, TN 37312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the doors protecting the corridors. The finding included: Observation during the fire drill on 10/21/13 at 12:29 AM,, revealed the corridor's fire door next to room 302 did not latch within the door frame. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/21/13.	K 018	K 018 1) The corridors fire door next to room 302 was immediately adjusted by the Maintenance Director to latch within the door frame on 10/21/2013. 2) All corridor fire doors were checked by the Maintenance Director to ensure latching within the door frame on 10/21/2013. No aberrances were noted. 3) The Fire Drill Documentation form was revised to include an audit of each corridor's fire door to ensure that it latches within the door frame by the Maintenance Director, and Administrator on 11-7-2013. 4) This Fire Drill Documentation audit will be completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator weekly for four weeks, and monthly thereafter. Aberrances will be corrected immediately. These audits will be reviewed quarterly by the Quality Assurance committee to include Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations.	11-26-2013 11-26-2013 11-26-2013 11-26-2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11-8-2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on testing and observation, it was determined the facility failed to maintain the exits. The finding included: Testing of the fifteen second delayed egress door at the end of the 100 hall on 10/21/13 at 11:45 AM revealed it did not release after fifteen seconds. The door did release upon alarm activation. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 10/21/13.	K 038	K 038 1) The door at the end of 100 hall was immediately reset at the key pad and checked for adjustment by the Director of Maintenance on 10-21-13; which then passed the 15 second test and opened properly. 2) All exit doors were checked by the Director of Maintenance on 10-21-2013 with aberrances corrected immediately. 3) An audit tool was developed by the Administrator to audit the exit doors on 11-7-2013. Exit doors will be tested for 15 second delay bi-weekly by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator. 4) This audit will be completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator bi-weekly. Aberrances will be corrected immediately. These audits will be reviewed quarterly by the Quality Assurance committee to include Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations.	11-26-2013 11-26-2013 11-26-2013 11-26-2013
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are	K 051	K 051 1) The Maintenance Director immediately contacted Century Fire Protection on 10-21-2013. Century Fire Protection ordered a special programing module on 10-22-2013.	11-26-2013

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K 051	Continued From page 2 maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6. This STANDARD is not met as evidenced by: Based on testing and observations, it was determined the facility failed to maintain the fire alarm. The finding included: Testing on 10/21/13 at 12:13 PM revealed the main Fire Alarm Control Panel and panel at the nurse's station did not show a trouble when the communication line was disconnected. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 10/21/13.	K 051	2) All residents have the potential to be affected. The Maintenance Director immediately contacted Century Fire Protection on 10-21-2013. Century Fire Protection replaced the dialer programming module on 10-24-2013. 3) An audit tool was developed by the Administrator to audit the remote annunciator for showing trouble when the phone lines are down on 11-7-2013; which will be completed by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator. 4) Audit will be completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator weekly for four weeks and monthly thereafter. Aberrances will be corrected immediately. These audits will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations.	11-26-2013 11-26-2013 11-26-2013
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K 062 1) The Maintenance Director immediately contacted Century Fire Protection on 10-21-2013. Century Fire Protection ordered the 8 sprinklers for the front entrance canopy on 10-31-20013. 2) The Maintenance Director immediately audited all sprinklers on 10-21-2013. No other aberrances were noted.	11-26-2013 11-26-2013

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system. The finding included: Observation on 10/21/13 at 10:35 AM, revealed the front entrance canopy had 8 corroded sprinklers. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/21/13.	K 062	3) Audit tool was developed by the Administrator to audit the sprinklers on 11-7-2013. This audit will be completed by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator. 4) An audit will be completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator weekly for four weeks and monthly thereafter. Aberrances will be corrected immediately. These audits will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services; Dietary Manager, Maintenance Director, and Activities Director for further recommendations.	11-26-2013 11-26-2013
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066	K 066 1) Director of Maintenance ordered metal containers with self-closing cover devices into which ashtrays can be emptied for the staff and residents smoking areas on 10/23/2013from Direct Supply. 2) There are no other smoking areas. 3) Review of the standard was completed by the Director of Maintenance, Assistant Director of Maintenance, and Administrator regarding use of metal containers with self-closing cover devices into which ashtrays can be emptied for the smoking areas on 10-21-2013. Observation of the metal containers with self-closing cover devices into which ashtrays can be emptied for the smoking areas will be reviewed monthly on the preventive maintenance log by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator. Aberrances will be corrected immediately.	11-26-2013 11-26-2013 11-26-2013

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K 066	Continued From page 4 permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to provide metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. The findings included: Observation on 10/21/13 at 11:55 AM, revealed there were no metal containers with self-closing cover devices into which ashtrays can be emptied at the staff and residents smoking areas. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/21/13.	K 066	4) Preventive Maintenance logs regarding the observation of the metal containers with self-closing cover devices into which ashtrays can be emptied for the smoking areas that were completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations. K 130 1) The Director of Maintenance and Assistant Director of Maintenance filled the following with 3M Fire Barrier sealant CP 25WB+ a) 300 corridor fire wall next to room 300 four penetrations, b) 100, 200, 300 and 400 corridor ceiling fire walls penetrations, c) top and sides of the 300 and 400 corridors wall penetrations, d) the service corridor fire wall, low voltage wires not sealed at the wall, e) around conduit through ceiling in electrical closet by the maintenance office penetrations on 11-11-2013.	11-26-2013 11-26-2013
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A fire barrier wall shall extend from the foundation or floor below to the underside of the roof or floor deck above. Any voids or gaps created by the meeting of the wall and floor below and the underside of the roof or floor deck above shall be filled with an approved material with a fire	K 130	2) Maintenance Director and Assistant Maintenance Director reviewed other areas for penetrations with aberrances corrected by 11-11-2013. 3) Review of the standard was completed by the Director of Maintenance, Assistant Director of Maintenance, and Administrator regarding Penetrations on 10-21-2013. Observation for penetrations will be reviewed monthly on the preventive maintenance log by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator. Aberrances will be corrected immediately.	11-26-2013 11-26-2013

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K 130	Continued From page 5 resistance rating at least equal to that of the fire wall. National Fire Protection Association (NFPA) 221, 3.2 Penetrations and miscellaneous openings in fire barriers such as pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. Based on observations, it was determined the facility failed to comply with the life safety code as required. The findings included: Observation on 10/21/13 at 10:58 AM,, revealed penetrations in the following areas: a. 300 corridor fire wall next to room 300, 4 penetrations in the wall. b. 100, 200, 330 and 400 corridor ceiling fire walls. c. Top and sides of the 300 and 400 corridors walls were not sealed at the fire walls. d. Service corridor fire wall, low voltage wires not sealed at the wall. e. Around conduit through ceiling in electrical closet by maintenance office. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/21/13.	K 130	4) Preventive Maintenance logs regarding the observation of penetrations completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator monthly will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations. K 0147 1) The Maintenance Director and Assistant Maintenance Director 1) moved the oxygen concentrator plugs from the power strips in room 405 and 302 to the emergency outlet, 2) removed the power strip form the Chaplains office 3) removed the power strip from the therapy room on 10-21-2013. 2) Audit of care and non-care areas was completed by the Maintenance Director and Assistant Maintenance Director to ensure no other power strips were plugged into multi-plug adapters, and medical equipment was plugged into the emergency outlet. This audit was completed on 10-23-2013. 3) Review of the standard was completed by the Director of Maintenance, Assistant Director of Maintenance, and Administrator regarding maintaining the electrical wiring, and equipment on 10-21-2013. Staff Development Coordinator, Administrator, and Director of Maintenance provided education to the facility staff regarding the use of power strips and to ensure medical equipment is plugged into the emergency outlets by 11-15-2013. Observation for use of power strips and medical equipment plugged into the emergency outlets will be reviewed monthly on the preventive maintenance log by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator. Aberrances will be corrected immediately.	11-26-2013 11-26-2013 11-26-2013
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147		11-26-2013

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K 147	Continued From page 6 with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical wiring and equipment. The findings included: 1. Observation on 10/21/13 at 11:04 AM revealed oxygen concentrators plugged into power strips in resident room 405 and 302. 2. Observation on 10/21/13 at 11:15 AM revealed back to back power strips in the chaplain's office. 3. Observation on 10/21/13 at 11:36 AM revealed a power strip plugged into a multi-plug adapter in the therapy room at the start of the 200 hall. These findings were acknowledged by the maintenance director and the facility administrator during the exit conference on 10/21/13.	K 147	4) Preventive Maintenance logs regarding the use of power strips, and medical equipment plugged into the emergency outlets completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator monthly will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations.	11-26-2013
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to	K 211	K 211 1) The Director of Maintenance moved Alcohol Based Hand Rub dispensers located over light switches in the therapy room, and in the central bath in the 300 hall on 10-21-2013. 2) The Director of Maintenance completed an audit of all Alcohol Based Hand Rub dispensers to ensure they were not installed over or adjacent to an ignition source on 10-25-2013. Aberrances were corrected immediately. 3) Review of the standard was completed by the Director of Maintenance, Assistant Director of Maintenance, and Administrator regarding where Alcohol Based Hand Rub Dispensers are installed on 10-21-2013. Observation for placement of Alcohol Based Hand Rub Dispensers placement will be reviewed monthly on the preventive maintenance log by the Director of Maintenance, Assistant Director of Maintenance, and/or Administrator. Aberrances will be corrected immediately	11-26-2013 11-26-2013 11-26-2013

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K 211	Continued From page 7 an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to ensure Alcohol Based Hand Rub (ABHR) dispensers were not installed over or adjacent to an ignition source. The finding included: Observation on 10/21/13 at 11:12 revealed ABHR dispensers located over light switches in the therapy room and in the central bath in the 300 hall. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 10/21/13.	K 211	4) Preventive Maintenance logs regarding observation for placement of Alcohol Based Hand Rub Dispensers placement that was completed by the Maintenance Director, Assistant Maintenance Director, and/or Administrator monthly will be reviewed quarterly by the Quality Assurance committee to include the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, Treatment Nurse, Skilled Unit Manager, Administrator, Medical Director, Nurse Practitioner, Social Services, Dietary Manager, Maintenance Director, and Activities Director for further recommendations.	11-26-2013